

**Park Allergy Center
Form Number 7.20a**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices.

Name of patient

Signature of patient or personal representative

If signed by personal representative, relationship to patient

Date

I further authorize the following person(s) to make the request for the use or disclosure of my Medical Information (PHI) on my behalf:

Myself Spouse: _____ Parent(s): _____

Child(ren): _____ Other: _____

Office Use Only:

Our practice will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If written acknowledgement is not obtained, our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

Refused to Sign Physically unable to sign
(Other) _____

Employee Signature: _____ Date: _____